7: Purnivall G-4, 5 (no date) 1948 AL1 Southeast Asia AL1

744 indeed are hardly suited to the cultivation of rice in mud and water. Much of the expenditure incurred in improving conditions on western enterprise is wasted if the adjacent villages continue to be sources of infection. But 'the Health Branch has to contend against the dead weight of a naturally indifferent and insanitary population' that, perversely, enjoyed 'general good health' without their attentions. Constant inspection is costly, and penalties are apt to raise the pitch of corruption rather than the standard of health. Even in a wealthy dependency with conditions so generally favourable as in Malaya, it has not been possible to do much towards improving the health of the ordinary villager.[1]

744 165 Yet one finds Malaya cited as 'one instance where the whole population benefited from medical and health organization assisted by economic development',[2] and it may be well to examine the evidence more closely. According to the Census Report on Malaya for 1931 the death-rate for Malaysians was 22·4 per 1000, for Chinese 24·3 and for Indians 29·8.[3] Since Malaysians receive least attention from the health service, it would seem that its activities play a minor part in reducing the bills of mortality. In Burma for the same year the provincial death-rate was returned as 17·36 and for rural areas, where western medicine and hygiene are practically inoperative, the death-rate, according to the official returns, was only 15·87.[4] But in Burma the apparently low death-rate was explained as due in part to 'slackness in registration', and this probably holds true also of Malaysians. It has been claimed that, in Malaya, 'the fall in infantile mortality is one of the best indications of what has been accomplished'.[5] Of recent years there has indeed been a marked downward trend in the figures, and this has coincided with greater activity in welfare work. In the Federated Malay States, the recorded death-rate for infants under twelve months fell from 218 per 1000 births in 1917 to 147 in 1937, and in the Straits Settlements during the same period it fell from 267 per 1000 to 156. But the first result of greater attention to vital statistics is an improvement in registration, and 'there is unfortunately no doubt that, even in such an area as Singapore Municipality, registration of births has up to quite recent years been very far from complete, and that even to-day it leaves a good deal to be desired'. The failure in registration in Singapore was estimated

[1] Mills, pp. 314–16, 328.
[2] *Social Policy in Dependent Territories* (1944), p. 6.
[3] Malaya Census, 1931, p. 10.
[4] *RAB*, 1931–2, p. 130.
[5] Mills, p. 328.

7: Furnivall G-4,5 (no date) 1948 AL1 Southeast Asia AL1

at 10 % in 1931, over 20 % in 1921 and over 35 % in 1911; yet 'the relevant statistics for Singapore are probably the best available'.[1] Death registration, however, is far more complete than birth registration, and it is certain that no inconsiderable part of the apparent decline of infantile mortality must be ascribed to the more accurate registration of births rather than to the attention to child welfare. Here, again, the figures for Burma are suggestive. In 1931, child welfare work did not extend beyond the towns, but the infantile mortality rate in rural areas was returned as 178 per 1000, whereas the corresponding figure for urban areas was 277. These figures may not prove that most children die where they receive most attention, but they do at least suggest a need for caution in accepting the figures for infantile mortality in Malaya as proof of the benefits accruing from the health service. If those figures are 'the best indication of what has been accomplished', it is unsound, in the face of evidence to the contrary, to conclude that the whole population has benefited.

In Malaya attention was directed to public health by the needs of private enterprise, and by the spread of disease as a result of economic development. European employers often go beyond the official minimum, and expenditure on the enforcement of regulations, as distinct from the provision of amenities, is chiefly incurred on western enterprises managed by non-Europeans, who cannot afford to comply with them or do not believe in them. Experience shows that the problem of improving the standard of health and the efficiency of labour on mines and plantations is ultimately linked up with the improvement of health among the people in general. But an improvement in the general standard of health among the people would seem to require that they shall comply with regulations in which they have no faith, and voluntarily accept rules which they are unable to obey and which the government is equally unable to enforce. In Singapore, as in Rangoon, conditions preclude the enforcement of the housing by-laws.[2] Where ill-health is the direct result of economic circumstances, the remedy lies not in legislation but in changing the environment. To most reforms, however, the chief obstacle is apathy. Without a change of attitude, expenditure on a health service as an instrument of welfare, or even as an instrument of economic progress, is largely wasted; given a change of attitude, most of the urgent reforms could be effected without spending large sums on a public health service, because common sense is sufficient to recommend

[1] Malaya Census, 1931, pp. 106, 108.

[2] Mills, p. 321 n.